Botulism

Agency:

Investigator:

Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Disease type Foodborne ☐ Wound ☐ Infant ☐ Adult intestinal toxemia ☐

Diagnosis date: / / Onset date: / /

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of death / /

Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Outbreak name:

Exposure setting:

Epi-linked: ☐ Yes ☐ No ☐ Unknown

Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown

State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Toxin Type: ☐ A ☐ B ☐ Other

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Toxin Type: ☐ A ☐ B ☐ E ☐ F ☐ Other

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Test type:

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Toxin Type: ☐ A ☐ E ☐ B ☐ F ☐ Other _____

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: Job title:

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name:

Date worked from: Address:

Date worked to: / / Zip code:

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: State: County:

Date removed: Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Occupation type: Job title:

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name:

Date worked from: Address:

Date worked to: / / Zip code:

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: State: County:

Date removed: Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry):

Admission date: / / Discharge date: / / Days hospitalized:

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms:

- ☐ Abdominal cramps
- ☐ Blurred vision
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diplopia (double vision)
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Erythema
- ☐ Fever
- ☐ Slurred Speech
- ☐ Vomiting

Preexisting wound 14 prior to onset? ☐ Yes ☐ No ☐ Unk

Wound location:

- ☐ Head
- ☐ Trunk
- ☐ Upper extremity
- ☐ Lower extremity

Wound type:

- ☐ Abrasion
- ☐ Avulsion
- ☐ Burn
- ☐ Compound fracture
- ☐ Crush
- ☐ Frostbite
- ☐ Linear laceration
- ☐ Puncture
- ☐ Stellate laceration

Wound depth: ☐ 1 cm or less ☐ >1 cm

Signs of infection: ☐ Yes ☐ No ☐ Unk

Contaminated: ☐ Yes ☐ No ☐ Unknown

Devitalized, ischemic, or denervated tissue: ☐ Yes ☐ No ☐ Unknown

Date wound occurred: / /

Setting:

- ☐ Automobile
- ☐ Farm/yard
- ☐ Petting Zoo
- ☐ Work
- ☐ Other _____

☐ Home

Other wound details:

Botox injections 14 days prior to symptoms? ☐ Yes ☐ No ☐ Unknown
(If Yes, complete the following section. If No, skip to the next section.)

Injection date: / / Facility name: Provider name:

Address: City: State: Zip:

County: Phone: ( )- - Type:

Tensilon test performed: ☐ Yes ☐ No ☐ Unk Date: / / **Results:** ☐ Positive ☐ Negative ☐ Equivocal ☐ Unknown

EMG test performed: ☐ Yes ☐ No ☐ Unk Date: / / **Compatible with Botulism diagnosis?** ☐ Yes ☐ No ☐ Unk

OTHER LAB FINDINGS

Food, medication or environmental samples tested? ☐ Yes ☐ No ☐ Unknown
(If Yes, complete the following section. If No, then skip to the next section.)

Tested for preformed toxin: ☐ Yes ☐ No ☐ Unk Laboratory: Toxin type: ☐ A ☐ B ☐ E ☐ F ☐ G

Describe samples: List positive samples:

Tested for C. botulinum or other serotype: ☐ Yes ☐ No ☐ Unk Laboratory:

Describe samples: List positive samples:

TREATMENT

For the illness, were any of the following treatments required:

Tracheotomy: ☐ Yes ☐ No ☐ Unk **Ventilator:** ☐ Yes ☐ No ☐ Unk Duration in days:

Antitoxins prescribed? ☐ Yes ☐ No ☐ Unk **Therapeutic medications prescribed?** ☐ Yes ☐ No ☐ Unk

Date started: List medications:

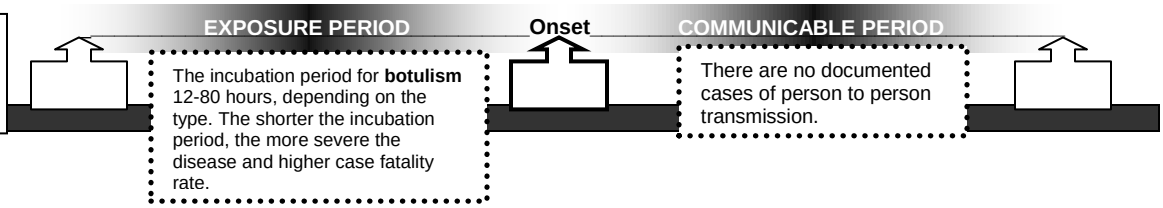
Dose: Unit: # times each day:

days:

Route:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



In the 36 hours prior to onset of symptoms did the case consume:

Home canned foods: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /
List all source/types: List all brand names:

Fish: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /
List all source/types: List all brand names:

Meat other than fish: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Potato or potato products:	☐ Yes ☐ No ☐ Unk	From dates consumed: ___/___/___	To dates consumed: ___/___/___
List all source/types: ______		List all brand names: ______	
Describe preparation:			
Other root vegetable:	☐ Yes ☐ No ☐ Unk	From dates consumed: ___/___/___	To dates consumed: ___/___/___
List all source/types:		List all brand names:	

In the 14 days prior to symptoms did the case Inject street drugs or steroids? ☐ Yes ☐ No ☐ Unknown

CONTACTS

Contacts with the same exposures ☐ Yes ☐ No ☐ Unknown

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	
			Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same foods consumed?	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	
			Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same foods consumed?	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	
			Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same foods consumed?	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	
			Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same foods consumed?	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

NOTES: